Special Section:
Supervision

group analysis

Internal and External Boundaries of Supervision

Rudolf Gregurek

This article proposes that supervision is an essential element of psychotherapy education and explains the relationship between internal and external boundaries of supervision. It is important that the boundary between the supervisory and the therapeutic relationship is clear. Each supervisor-supervisee negotiates the intimacy and content of the supervision according to their style and needs; there are clear differences between the tasks of the two relationships. It is important to understand any controversy as to the degree to which the supervision should serve as an exploration of the supervisee's countertransference (internal boundaries) versus conflict inherent in the roles of supervisor in institutes where the supervisor is also the superior or older colleague of the supervisee (external boundaries).

Key words: supervision, psychodynamic training, group analysis, countertransference, boundaries

Psychotherapy supervision began in the 1920s when Max Eitington, a psychoanalyst in Berlin, proposed that psychoanalysts in training should conduct supervised psychoanalysis sessions. The 'tripartite' model of analytic training consisted of didactic course work, supervised treatment of several patients, and personal analysis (Freud, A., 1971; Freud, S., 1912). This

Group Analysis. Copyright © 2007 The Group-Analytic Society (London), Vol 40(2):167–177.
DOI: 10.1177/0533316407077070 http://gaq.sagepub.com

model remains the prototype for all forms of psychodynamic therapy training, and retains this position on the basis of established tradition and faith as opposed to empirical evidence for its effectiveness.

Supervision of actual therapies has always been considered the most important component of psychodynamic training (Arlow, 1963). The most prevalent model is characterized by an integration of didactic and therapeutic roles, within which the typical supervisor applies psychodynamic theories and methods to achieve educational goals. A cardinal example is the popular view among psychoanalytic supervisors that the supervisory relationship is organized around a 'parallel process' (Doehrman, 1976). In this conception, similar interpersonal dynamics are concurrently enacted in the therapy dyad and in the supervisory dyad (Alonso, 1993). The supervisor can use familiar clinical skills to identify various 'resistances to learning' on the part of the trainee, much like the supervisor would deal with a patient's transference resistances. The use of clinical strategies to achieve educational goals is not surprising, because clinical supervisors are rarely trained in pedagogic theories, principles, and methods specifically tailored to the supervision process (Caligor et al., 1984). Therefore, they use the knowledge and skills with which they are most familiar and comfortable.

An essential aspect of training is for the aspiring psychotherapist to undertake treatment of patients under the guidance of an experienced practitioner. Supervision is a relationship into which the supervisee enters with the experienced supervisor. The basic structure of this relationship is that the supervisee reports, and the supervisor listens and offers advice. The supervisee reports and otherwise discusses what is happening in therapy with his or her patients. The supervisor listens, and gives feedback to the supervisee, with the two primary objectives of protecting the supervisee's clients from potential negative effects of the supervisee's inexperience, and improving the supervisee's skill as a therapist.

Psychotherapists aim directly to modify the deep patternings of people's ways of being-in-the-world. Supervision of psychotherapy shapes the kinds of interventions therapists make. In psychotherapy, the therapist's personality should be neither subdued nor displayed unnecessarily, but rather incorporated into the therapist's function in a way that the person of the therapist

remains active and responsive. However, the use of one's personality as an instrument in a working relationship comes slowly to many. Thus, supervision can also teach therapists how to subordinate their own unique personality to the task of psychotherapy (Schafer, 1983).

Supervision of psychotherapy is a communicative relationship which consists essentially of a therapist-in-training discussing with a more experienced therapist the student's therapeutic efforts with patients. The more experienced therapist provides guidance to the student's work, and, usually in actual practice (although not as a logical necessity), also evaluates the student's progress toward meeting requirements for graduation from the training program in which the student is enrolled.

First, a therapist needs to know him/herself; his/her manner, style, and presence as a therapist in general; and with particular patients or groups, his/her transference valence – that is based upon his/her way of being in the world and in a therapy relationship. He/she may also have some ideas about what transference responses he/she can expect from particular patients given his/her experiences and adaptations.

The supervisor mixes and matches, attending to the supervisee's needs for help in professional development and the supervisee's patients' needs for therapeutic help; part of the supervisor's attention, perforce, must focus on the supervisee, if only to deal with difficulties transmitting instructions via the supervisee to the patient, and getting back the patient's responses through the supervisee. Here, the alternatives – and it is not an 'either/or' situation but rather a question of how much of each alternative to employ – are: 1) to teach the supervisee what he or she does not already know, in order to overcome errors due to ignorance; and 2) to treat the supervisee's personal problems which interfere with the supervisee effectively implementing what he/she already is, in a way.

The relationship between supervisor and supervisee in a psychotherapist's training is a complex communicative situation which, ideally, is a conversation about conversation: communicative action between supervisor and supervisee oriented toward nurturing communicative action between supervisee and patient (Sharpe, 1995). The evaluative reporting role of the supervisor and communication in the supervisory situation can become mystified, manipulative and strategic. Due to factors such as

narrowly-technical pedagogical orientation, the conversation between supervisor and supervisee can be 'conversational' but have, as its content, planned strategic communication vis-à-vis an objectivized client.

In both these arenas the supervisor can be an invaluable resource. When the supervisor invites the therapist to notice his/her experience in the room with a patient, to notice details of his/her presence, behavior, style, and impact on the patient, the supervisor opens up these issues for examination and discussion and teaches the therapist to use him/herself as his/her best therapeutic tool.

Just as in the psychotherapy relationship, a supervisory relationship has boundaries and a frame. The specifics of the frame will vary based on the contract and the needs, resources and roles of the therapist and supervisor, which should be delineated explicitly at the outset of the supervision. Therapist and supervisor need to address such issues as confidentiality, legal responsibility, evaluation, time, fee, frequency and availability of the supervisor. The interpersonal climate of the supervision is also crucial. In order for a supervisee to be able to address his/her insecurities, confusion and complicated feelings, the relationship must focus on safety, trust, respect, and clear boundaries (Alonso and Rutan, 1988).

The relational focus of the supervision is further enhanced by attention to the parallel process between the supervisory relationship and therapeutic relationship (Bromberg, 1982; Caligor, 1981). The parallel is inevitable and useful. It can be as straightforward as the therapist who wants to know how to deal with an inconsolable, anxious patient, yet rejects every suggestion made by the supervisor until the parallel process is pointed out. Sometimes the parallel is more subtle – for example, when the supervisor participates in an empathic failure by repeatedly responding to content and focusing on therapeutic action, rather than simply sitting with a therapist's affective experience (Brightman, 1983). Through recognition and discussion of the processes within the supervisory relationship, supervisor and therapist can recognize unconscious patterns in the therapeutic relationship.

Whenever a learner's efforts are examined there is potential for anxiety. Where a technical skill is being acquired, however, the threat to the learner's self-esteem is relatively narrowly circum-

scribed. Nobody is expected to acquire dexterity in, e.g. surgery, without practice. A surgeon in training first develops his/her skills on animals and cadavers, then is gradually given more demanding roles in real operations. Mistakes are expected and experienced practitioners are at hand to help the learner get it right. In learning a technical skill, only exceptionally inept students are likely to suffer serious damage to their self-esteem, and, even then, the failure does not cut so deep, since not everybody has the potential to do equally well in every kind of skilled activity.

Supervision is this kind of communicative interaction between supervisor and supervisee. If a patient needs to be removed from an abusive home situation, there are social welfare and other resources to help deal with the situation, and the supervisee has to learn these. Following the supervisor's advice in handling such matters is, for a psychotherapist, like a surgery intern following a surgeon's advice in suturing up an incision. There may be interpersonal 'issues': a supervisor may tell the supervisee what to do in an unnecessarily authoritarian way which makes the student feel demeaned; the supervisee may feel it is not part of his/her identity as a 'group analyst,' albeit in training, to do this kind of 'social work'. But these problems can usually be smoothed over with reasonable sympathetic encouragement from the supervisor (or else, the supervisee may soon enough find out he/she does not really like the work).

In supervision of the core communicational aspects of therapy, the potential threat to the supervisee's self-esteem is massively greater (Brightman, 1983). Logistically, there is far less opportunity to introduce the supervisee to the complexities of the work in a graduated way. Even when training cases are carefully selected, so that training institute faculty believe the supervisee has been provided with a patient whose problems are within the supervisee's ability to handle with the help of the supervisee's supervisor (and possibly other support resources), from his or her very first therapy session, the supervisee generally walks into a room with the patient and shuts the door, and, for the next 'hour' is 'on his or her own' somewhat as if a surgery intern's introduction to the operating room was a patient anesthetized on the table and the nurses standing by to follow the intern's orders, but there is nobody available to give him/her advice; and since psychological 'diagnoses' are far more uncertain

than pre-surgical medical evaluations, it is always possible that the patient will do 'anything'. The pressure on the student psychotherapist's performance is immense.

Even more anxiety-producing – no matter how much their training program may tell supervisees that they are learning a 'skill', the underlying situation is always the communicative relationship between therapist and patient. It is possible that supervisees are often confused about this and that their training (iatrogenically) makes them confused by teaching them all sorts of theory and technique and not emphasizing the basic communicative nature of their work. The two fundamental pedagogical objectives on which psychotherapist training should focus are: 1) developing interpersonal communication, especially conversational competence, sensitivity and confidence; and 2) learning case management skills. Without this foundation firmly in place, 'personality theory', 'psychopathology', 'therapeutic technique', etc. – the content matter which occupies center stage in training programs – is all, at best, ineffectual and at worst, frequently deleterious (supervisee-supervisors will often interact with patients in insensitive ways because their training has taught them it is 'good technique').

When the therapist in training makes a 'mistake', it is generally not analogous to a faulty suture on an anesthetized surgical patient, which the overseeing surgeon can rectify without the patient even noticing it. The psychotherapist's patient feels the 'mistake'. Since patients often have sought therapy in part because they are sensitive to being hurt, the impact of the student's mistake on a patient may be magnified. The underlying threat to the supervisee's self-esteem here is that no matter how much their training may tell them that therapy is a technical skill or a 'science', so long as a thoroughly objectivating attitude is not adopted toward the patient, the supervisee's interactions with patients are conversation, and a supervisee's 'mistake' is also a failure of simply human empathy with a fellow person.

The communicative interaction of supervision of psychotherapy has as an intrinsic part of its content the supervisee's personal character and overall sense of 'who he or she is'. An essential part of what is examined in supervision is 'who the supervisee really is,' as revealed in his or her work with clients, as well as in his or her interaction with the supervisor concerning this highly sensitive material.

There are a variety of alternatives in which a group of supervisees meets with a single supervisor ('group supervision'), which would also be interesting to study, especially in regard to how group dynamics affect the supervisory process differentially from the intimacy of a one-on-one situation (Aronson, 1990). Some writers argue that the group situation reduces the supervisor's potential to intimidate the supervisee, and the supervisee's potential to over-identify with the supervisor (etc.), by introducing the multiple points of view and mutual support of the several supervisees vis-à-vis the supervisor (technically, this is called 'diluting the transference'). On the other hand, the group situation can foster conformity, since it may be more difficult for an individual to assert him/herself vis-à-vis a group's 'consensual reality' than against the position of another individual who, even if more experienced, socially powerful, etc., is nonetheless ontologically the person's equal.

When a group of people first come together for supervision, their focus is often initially on patients rather than on the therapy relationships or the therapist. It is helpful for participants to discuss early on what frame and structure would enhance each person's comfort for sharing his/her struggles and feelings about the therapies he/she is discussing. Talking about the process among the group members can help set the stage for discussing the process of the therapies, as well as the more personal issues of countertransference (Salvendy, 1985).

The supervisor must be supportive for a supervisee to feel comfortable bringing his patient's evaluative experience to the supervisor. The supervisor can model exploration of interpersonal interactions by his/her willingness to notice, name, and discuss interaction in the supervision. A supervisor must be non-defensive in response to the supervisee's questions, disappointments, anger, hurt or anxiety, just as the patient needs the therapist to hear his/her experience without becoming defensive (Langs, 1989).

Ideally, supervision provides a respectful forum in which supervisee and supervisor can identify and examine possible countertransference dynamics (James, 1979). These responses are complicated, personal, often painful or embarrassing. It is important for the supervisor to normalize countertransference, then facilitate the supervisee's abilities to make clinical and

personal use of his/her responses. This process includes interpreting countertransference, focusing on what clues or information the countertransference provides the supervisee about him/herself, the patient and the therapeutic relationship.

It is important that the boundary between supervision and personal psychotherapy is clear. Each supervisor-supervisee pair negotiates the intimacy and content of the supervision according to their style and needs; there are clear differences between the tasks of the two relationships. A supervisor does not have licence to make interpretations, yet is inviting the supervisee to reflect on his countertransference. This is a fine line, and each pair will find its own comfort level which may shift as they come to know and trust one another. When a supervisor invites a supervisee to note his/her countertransference thoughts, feelings, associations and behaviors, the framework for working with that material needs to be clear.

It is not the supervisor's role to invite transference. While transference responses to the supervisor are inevitable, the supervisory contract is generally not to invite or explore them in depth, except as they reflect a parallel process with the therapy. At times, a supervisor recommends a supervisee to enter or resume personal therapy when issues beyond the scope of supervision seem to be relevant in his/her psychotherapies.

One realm within supervision in which boundary issues and other therapeutic processes will emerge is in the parallel process (Doehrman, 1976). While both supervisee and supervisor hope ultimately to serve the best interests of the patient, the primary function of the supervisory relationship is to provide support and education for the supervisee (Pedder, 1986). In this context, parallel process enactments commonly reflect dynamics around dependence, boundaries, self-esteem, safety and control.

The supervisory relationship can allow the experience of issues and the freedom to notice relational patterns in the supervision (such as chronic lateness, sessions running over their allotted time, forgetting notes or clinical material, filling the hour with detailed reports of clinical material and leaving no time for the supervisor's response, etc.). This requires some active structuring on the part of the supervisor, especially early on in the relationship, including asking questions, making observations, and inviting the supervisee to note his/her own experience, both in the therapy and in the supervision.

The conflict inherent in the roles of supervisor is also experienced by many supervisees in institutes or agencies where the supervisor is also their superior (Kernberg, 1986). The ideal therapy supervision is one in which the supervisee feels free to share all of his/her thoughts, feelings and fantasies about the patient, all of his/her struggles about the work, and to explore his/her unconscious associations to the patient and his material. This kind of freedom is rare in a situation where the supervisee is also being evaluated or felt like that. Where they converge, it is imperative that both the supervisor and the supervisee know the boundaries of the relationship, for example: What is the basis for the evaluation? What are the limits of confidentiality in the relationship? Who else has access to the evaluation? What will it include? The supervisor should be attuned to themes in the supervisee's material that relate to issues of judgment and evaluation and name these themes as they arise, both to increase the safety of the supervisory relationship and to model the naming of issues related to esteem and trust.

The role of supervisor is quite different from one of a therapist; one listens differently, responds differently and has different responsibilities. Nonetheless, there are also parallels, including potential transference from supervisee to the supervisor and countertransference from the supervisor to both the supervisee/therapist and the patient. Supervision is hard work; the supervisor will be aware of multiple levels of meaning and patterns of relationships (Sharpe and Blackwell, 1987). He/she will hear both the patient's and the supervisee/therapist's feelings and distress and may feel pulled to respond to their wish for relief and helpful intervention on his/her part. The wish for the supervisor to be an expert can interact with his/her self-expectations.

The supervision is more likely to be satisfying and successful for all parties if the supervisor thinks in advance about how to structure it, both to meet his/her needs and to facilitate the supervisee's growth and his/her therapeutic relationship with a patient. Supervision can be enormously rewarding and a wonderful learning experience for both the supervisor and the supervisee (Langs, 1989). It is a way we all work in connection with others, sharing the power of this meaningful work, honoring the complexity of the process, validating our needs for support and sharing wisdom and experience.

The recognition of the power of transference can hardly be learned without supervision. Various psychotherapeutic modalities manage transference differently, but the recognition of the transference through supervision prevents problems related to the patient's growing emotional response to the therapist, which could interfere with the process of treatment.

The transference is conceived as a special manifestation of the unconscious process that influences every thought and action (Freud, S., 1912). The contact with that unconscious process, either by transference or other manifestations, may be the most important lesson in psychodynamic supervision. Though many supervisees accept the concept of unconscious activity at a rational level, only by direct contact with unconscious activity in a patient (or as a patient!) can the concept come to live as a clinically relevant force in the psychopathology and treatment of emotional disturbance (Salvendy, 1993). The beginner therapist will naturally attend to the manifest material. With help, supervisees can tune into the viewpoint that things are not always what they seem and that meaning exists on multiple levels during human communication.

We could say that, just as the concert stage is not the best place to practise basic piano technique, the therapy session may not be the best place to first practise basic therapy technique.

I believe all therapists have an ethical as well as personal responsibility to engage in regular, frequent clinical supervision on their psychotherapeutic work. That is why the supervisor has an important role to strictly define and test internal and external boundaries of the supervision process because it is possible for boundaries to become permeable and lose their explicit task.

References

Alonso, A. (1993) 'Training for Group Psychotherapy', in A. Alonso and H.I. Swiller (eds) *Group Therapy in Clinical Practice*, pp. 521–32. Washington, DC: American Psychiatric Press.

Alonso, A. and Rutan, J.S. (1988) 'Shame and Guilt in Psychotherapy Supervision', *Psychotherapy: Theory, Research, and Practice* 25(4): 576–81.

Arlow, J.A. (1963) 'The Supervisory Situation', *Journal of American Psychoanalytic Association* 2: 576–94.

Aronson, M.L. (1990) 'A Group Therapist's Perspectives on the Use of Supervisory Groups in the Training of Psychotherapists', *Psychoanalysis and Psychotherapy* 8(1): 88–94.

Brightman, B.K. (1983) 'Narcissistic Issues in the Training Experience of the Psychotherapist', *International Journal of Psychoanalytic Psychotherapy* 10: 293–317.
Bromberg, P.M. (1982) 'The Supervisory Process and Parallel Process in Psychoanalysis', *Contemporary Psychoanalysis* 18(1): 92–110.
Caligor, L. (1981) 'Parallel and Reciprocal Process in Psychoanalytic Supervision', *Contemporary Psychoanalysis* 17(1): 1–26.
Caligor, L., Bromberg, P.M. and Meltzer, J.D. (eds) (1984) *Clinical Perspectives on the Supervision of Psychoanalysis and Psychotherapy*. New York: Plenum.
Doehrman, M.J.G. (1976) 'Parallel Process in Supervision and Psychotherapy', *Bulletin of the Menninger Clinic* 40(1): 3–104.
Freud, A. (1971) *Problems of Psychoanalytic Training, Diagnosis, and the Technique of Therapy*. New York: International Universities.
Freud, S. (1912) 'The Dynamics of Transference', *Standard Edition* (Vol. 12, pp. 97–108). London: Hogarth, 1958.
James, D.C. (1979) 'Countertransference in Training', *Group Analysis* 12(1): 45–52.
Kernberg, O.F. (1986) 'Institutional Problems of Psychoanalytic Education', *Journal of the American Psychoanalytic Association* 34: 799–834.
Langs, R. (1989) 'Reactions of Supervisees (and Supervisors) to New Levels of Psychoanalytic Discovery and Meaning', *Contemporary Psychoanalysis* 25(1): 76–97.
Pedder, J. (1986) 'Reflections on the Theory and Practice of Supervision', *Psychoanalytic Psychotherapy* 2(1): 1–12.
Salvendy, J. (1985) 'The Making of the Group Therapist – The Role of Experiential Learning', *Group* 9(4): 35–44.
Salvendy, J. (1993) 'Control and Power in Supervision', *International Journal* of *Group Psychotherapy* 43(3): 363–76.
Schafer, R. (1983) *The Analytic Attitude*. New York: Basic Books.
Sharpe, M. (ed.) (1995) *The Third Eye: Supervision of Analytic Groups*. London: Routledge.
Sharpe, M. and Blackwell, D. (1987) 'Creative Supervision Through Student Involvement', *Group Analysis* 20(3): 195–208.

Rudolf Gregurek is a psychiatrist, psychotherapist and group analyst, Professor of Psychological Medicine in the Department of Psychiatry, University of Zagreb Medical School and Head of Clinic for Psychological Medicine at the Clinical Hospital Centre, Zagreb. *Address*: Clinical Hospital Centre Zagreb, Clinic for Psychological Medicine, Kispaticeva 12, 10000 Zagreb, Croatia. *Email*: gregurek@mef.hr